DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 03-06

2. STATE: **ILLINOIS**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE:
April 28, 2003

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☒ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☐ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Sections 1905 (a)(26) and 1934 of the Soc. Sec. Act

7. FEDERAL BUDGET IMPACT
a. FFY 03 $1,253,000
b. FFY 04 $1,002,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4-19 A pages 127, 128

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4-19 A pages 127, 128

10. SUBJECT OF AMENDMENT:
Critical Hospital Adjustment Payments

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☒ OTHER, AS SPECIFIED:
Not submitted for review by prior approval.

12. SIGNATURE OF AGENCY OFFICIAL:
Barry S. Maram

13. TYPED NAME: **Barry S. Maram**

14. TITLE: **Director of Public Aid**

15. DATE SUBMITTED: JUN 23 2003

16. RETURN TO:

Illinois Department of Public Aid
Bureau of Program and Reimbursement Analysis
201 South Grand Avenue East
Springfield, IL 62763-0001
Attention: Greg Wilson

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: JUN 30 2003

18. DATE APPROVED: JAN 12 2004

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: APR 28 2003

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Charlene Brown

22. TITLE: Deputy Director, CMSO

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

STATE OF ILLINOIS

METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL REIMBURSEMENT: MEDICAL ASSISTANCE-GRANT (MAG) AND MEDICAL ASSISTANCE-NO GRANT (MANG)

4/28/03 3. Hospitals qualifying under subsection C.1.b. of this Chapter will receive the following rates:
   a. Qualifying hospitals will receive a rate of $303.00 per day.
   b. Qualifying hospitals with the more than 1,500 Obstetrical days will have their rate increased by ~~$262.00~~ $487.00 per day.

10/02 4. Hospitals qualifying under subsection C.1.c. of this Chapter will receive the following rates:
   a. Hospitals will receive a rate of $28.00 per day.
   b. Hospitals located in Illinois and outside of HSA 6, that have a Medicaid inpatient utilization rate greater than 60 percent, will have their rate increased by $55.00 per day.
   c. Hospitals located in Illinois and inside HSA 6, that have a Medicaid inpatient utilization rate greater than 80 percent, will have their rate increased by $403.00 per day.
   d. Hospitals that are not located in Illinois that have a Medicaid inpatient utilization rate greater than 45 percent will have their rate increased by $32.00 per day for hospitals that have less than 4,000 total days; or $246.00 per day for hospitals that have greater than 4,000 total days but less than 8,000 total days; or $178.00 per day for hospitals that have greater than 8,000 total days.
   e. Hospitals with more than 3,200 Total admissions will have their rate increased by $248.00 per day.

5. Hospitals qualifying under subsection C.1.d. of this Section will receive the following rates:
   a. Hospitals will receive a rate of $41.00 per day.
   b. Hospitals with a MIUR between 18 percent and 19.75 percent will have their rate increased by an additional $14.00 per day.
   c. Hospitals with a MIUR equal to or greater than 19.75 percent will have their rate increased by an additional $87.00 per day.
   d. Hospitals with a combined MIUR that is equal to or greater than 35 percent will have their rates increased by an additional $41.00 per day.
6. Hospitals qualifying under subsection C1.e above will receive $188.00 per day.
7. Hospitals qualifying under subsection C.1.f. of this Section will receive a rate of $55.00 per day.
8. Hospitals qualifying under subsection C.1.a.iii. above will have their rates multiplied by a factor of two.

APR 28 2003

STATE OF ILLINOIS

METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL REIMBURSEMENT: MEDICAL ASSISTANCE-GRANT (MAG) AND MEDICAL ASSISTANCE-NO GRANT (MANG)

4/28/03 9. DHA Payments

a. Payments under this subsection D will be made at least quarterly, beginning with the quarter ending December 31, 1999.
b. Payment rates will be multiplied by the Total days.
c. Total Payment Adjustments
   i. ~~For the CHAP rate period occurring in State fiscal year 2003, total payments will equal the methodologies described above. For the period October 1, 2002 to June 30, 2003, payment will equal the State fiscal year 2003 amount less the amount the hospital received under DHA for the quarter ending September 30, 2002.~~ For the period April 28, 2003 to June 30, 2003, a quarterly payment will be made that is equal the State fiscal year 2003 amount less the amount the hospital received under DHA for the quarters ending September 30, 2002, December 31, 2002, and March 31, 2002.
   ii. For CHAP rate periods occurring after State fiscal year 2003, total payments will equal the methodologies described above.
d. Payments under this subsection D that are made to disproportionate share hospitals in accordance with Chapter VI.C.7 will be considered to be disproportionate share payments, until September 30, 2002, except for payments made to hospitals as defined in Chapter XIII.

E. Rural Critical Hospital Adjustment Payments (RCHAP)

Rural Critical Hospital Adjustment Payments (RCHAP) shall be made to rural hospitals as defined in Chapter XVI(B(3)) for certain inpatient admissions. The hospital qualifying under this subsection that has the highest number of Medicaid obstetrical care admissions during the CHAP base period shall receive $367,179.00 per year. The Department shall also make a RCHAP adjustment payment to hospitals qualifying under this subsection at a rate that is the greater of:

1. the product of $1,367.00 multiplied by the number of RCHAP Obstetrical Care Admissions in the CHAP base period, or
2. the product of $138.00 multiplied by the number of RCHAP General Care Admissions in the CHAP base period.

F. Total CHAP Payment Adjustments - Each eligible hospital's critical hospital adjustment payment shall equal the sum of the amounts described in sections A, B, C and E of this Chapter. The critical hospital adjustment payments shall be paid at least quarterly.